CHILDREN AND FAMILIES COMMISSION

OF SAN LUIS OBISPO COUNTY

RAISING OUR FUTURE

STRATEGIC PLAN
EXECUTIVE SUMMARY

FOR CHILDREN AGES 0-5 AND THEIR FAMILIES

June, 2000

Children are one-third of our population and all of our future.
Select Panel for the Promotion of Child Health, 1981

VISION STATEMENT

Children in every community of San Luis Obispo County will thrive in supportive, nurturing and loving environments, enter school healthy and ready to learn, develop resilience, and become productive well adjusted members of society.

MISSION STATEMENT

The Children and Families Commission of San Luis Obispo County will identify and allocate funds for programs and services that enhance early childhood development, recognizing the critical nature of early brain development.

We serve children, pre-natal to age five, and their families to ensure that every child is healthy and ready to learn in school.

We believe all children in San Luis Obispo County deserve to reach their potential in a nurturing and healthy environment.

A. INTRODUCTION TO THE STRATEGIC PLAN

Young childhood is a critically important period of time. The experiences young children have, and the conditions in which they live, greatly influence the kinds of adults they will become. In ways that science is just now beginning to understand, and that our society is not even close to acknowledging, intellect, emotions, social interaction, and physicality in adulthood are intimately linked with childhood development. Deprivation at an early age, even conditions in the womb, can substantially, perhaps irreversibly retard development, and, therefore, can affect a person's entire life.

The Children and Families Commission of San Luis Obispo County was created as a result of the passage of Proposition 10 in November, 1998. Its intent is to provide a comprehensive and integrated system of prevention and early intervention services for children ages zero to five years and their families in order to help our county's young children to grow and develop to their maximum potential.

In developing their Strategic Plan the Commission has acted on the premise that parents are the single most important resources in early child development. The Commission wishes to assist parents in providing a safe, nurturing, and stimulating environment for all of the children in San Luis Obispo County.

GUIDING PRINCIPLES

The Children and Families Commission of San Luis Obispo County will bring programs together to provide high quality, outcome-based, integrated services to families in San Luis Obispo County. The Commission is dedicated to:

1) mobilizing the community around critical issues affecting young children and their families and identifying approaches that begin to meet their highest or broadest needs;
2) considering opportunities for leveraging or matching revenue with other private, local, state, or federal programs;
3) considering long-range financial planning based on the expectations that county allocations will become a dwindling revenue source; and
4) considering research findings in selecting the most effective programs and strategies.

The Children and Families Commission's decision-making is guided by mutually agreed upon standards. The Commission will:

- Develop a comprehensive, integrated service delivery system of early childhood development services.
- Engage in an ongoing, dynamic, and evolving strategic planning process to meet the changing needs of all communities.
- Ensure community participation in the planning process, including ethnic/cultural, income, and geographic diversity.
- Support programs to reduce the effects of adverse health risks such as secondhand smoke, other substance abuse, and family violence on infants and young children.
- Build upon existing resources and research to avoid duplication of effort during strategic plan development.
- Respect the cultural diversity among us by providing outreach to all communities in San Luis Obispo County, including families with special needs or those socially isolated.
- Encourage systems of care where services and projects are integrated into easily accessible child and family centered systems.
- Ensure positive outcomes for children and their families by evaluating program impacts on children and families.
- Support efforts to maintain program services and research by leveraging and/or obtaining additional matching grant funds for program enhancement and sustainability.
- Support access to services for all families in an environment of support and respect.
- Encourage and support the development of each community's capacity to provide integrated services.

B. STRATEGIC PLANNING PROCESS

The mandate for local commissions from the California Children and Families First Act of 1998 (Proposition 10) is to assess needs, plan, and implement strategies and activities within three Focus Areas:

Parent Education and Support Services;
Child Care and Early Education; and
Health and Wellbeing of Children.

The Children and Families Commission of San Luis Obispo County prepared the Strategic Plan through four steps. First was the collection of data regarding needs in the county. Second came concerted efforts to solicit community input through eight community meetings and four parent focus groups. Third, the Commission engaged in a thorough analysis and prioritization of needs as well as the development of a budget, timeline, and allocation process for funding new services and activities. Finally, the Executive Summary of the Strategic Plan was distributed throughout the county, and the Commission held a second round of public forums to solicit community input on the Strategic Plan before its final adoption.

C. STRATEGIC PLAN

The Children and Families Commission of SLO County plans to achieve its vision in three ways:

1) Allocation of funds available to the Commission through Proposition 10.
2) Advocacy for expanded funding from other sources.
3) Increasing awareness of the importance of early childhood development, and advocating for policies supportive of young children and their families.

This outline of the Strategic Plan summarizes the first *phase of action*, allocating funding available to the Commission through Proposition 10. The Commission has developed a plan for meeting needs within each of the three Focus Areas. The plan includes prioritized needs, goals and objectives, strategies and activities, and indicators and outcomes, a summary of which may be found in the table on the next pages. The Commission is committed to funding services which are sensitive to and competent regarding the language and culture of each community in the county.

D. ALLOCATION OF PROPOSITION 10 FUNDS

The final tasks during the planning process were to adopt a budget for the dissemination of Commission funds, to develop a timeline for funding, and to create an allocation process. The proposed budget for annual use of Proposition 10 funding is:

ANNUAL PROPOSITION 10 ALLOCATION BUDGET TABLE

Expense Category			Allocation Percentage (Amount)
DIRECT SERVICES PROVISION **Parent Support/Education** **Early Child Care and Education** **Health and Wellbeing of Children**			**72%** **($1,800,000)**
INVESTMENT RESERVE			**10%** **($250,000)**
OPERATING RESERVE			**5%** **($125,000)**
EVALUATION/DATA			**4%** **($100,000)**
INFRASTRUCTURE SUPPORT			**9%**
• Administration	7.9%	($197,500)	**($225,000)**
• Training - Agency	0.5%	($ 12,500)	
• Media/Marketing	0.6%	($ 15,000)	
TOTAL			**100%** **($2,500,000)**

Direct services will be funded through grants awarded in a request for proposals (RFP) process. The first awards will be for a two-year period, and will unfold according to the following timeline:

ALLOCATION TIMELINE FOR PROPOSITION 10 FUNDS

Funding Cycle	RFP Release	Proposal Due	Awards Made	Funding Begins	Funding Ends
One	8/00	10/00	12/00	1/01	12/02
Two	2/02	4/02	6/02	7/02	TBA

Proposals will be reviewed by objective committees. Final funding decisions will be made by the members of the Children and Families Commission of San Luis Obispo County.

The Commission realizes the scope of its vision. The Strategic Plan is ambitious, and will take a number of years to implement. It is a work in progress. With the continuing and considerable involvement of the community, the plan will continue to evolve as long as the Commission is in operation.

Strategic Plan Summary Table

PARENT EDUCATION AND SUPPORT

Prioritized Needs & Goals and Objectives	Indicators & Outcomes	Strategies & Activities
Prioritized Need 1) Prenatal and post-delivery education **Goal:** To prepare parents of newborns for the demands of parenting in order to promote healthy pregnancies and newborns, to increase the ability of parents to provide safe and nurturing homes, and to provide early identification of problems and referrals to services for families in need. **Objectives:** • To provide visitation and initial screening for 75% of pregnant women prior to hospitalization and for 95% of newborns and their families prior to hospital discharge (within 2 years of implementation). • To complete a standardized family wellbeing assessment of 50% of the families by the third visit. (within 2 years of implementation) • To provide extended visitation for up to six months to 95% of the assessed families that are determined to be in need of such support.	**Indicators:** • Increased number of expecting parents who receive parenting information prior to birth. • Increased number of parents of newborns who receive parenting information while in the hospital. • Increased rate of participation in WIC, MediCal, and Healthy Families. • Increased rate of participation in parent education programs. **Outcomes:** • Decreased rate of late or no prenatal care. • Increased rate of prenatal care begun in the first trimester. • Decreased rate of home injuries to young children. • Decreased rate of child abuse and neglect. • Increased rate of use of existing services and programs.	**Strategies**: • Home and hospital visitation programs - visitation may be made by a public health nurse, parent mentor, social worker, or others. Home visits could be made to pregnant mothers, parents in the hospital at the of time birth, and/or to families in their homes after discharge. Both the Cal SAHF and Hawaii programs are considered appropriate models. **Activities:** • Educational materials (e.g., *Welcome Baby Kits*). • Information on existing programs and services. • Respite care. • Parent mentoring. • See also Need #2 under the Health & Wellbeing of Children Focus Area for other in-home activities.
Prioritized Need 2) Parenting skills training **Goal:** To improve the ability of parents to recognize and respond in an appropriate, positive, and nurturing manner to the needs of their young children. **Objectives:** • To have at least 75% of the parents involved in parenting education courses complete the training (within 2 years of implementation). • To increase the knowledge of participating parents regarding child development and parenting skills by at least 60% (within 2 years). • To augment education and counseling concerning child abuse.	**Indicators:** • Increased number of high quality parenting classes in all regions of the county. • Increased number of parents attending high quality parenting skills training classes. **Outcomes:** • Increased rate of family self-sufficiency. • Decreased rate of child abuse and neglect. • Decreased rate of domestic violence.	**Strategies**: • It is important that parent education enhance existing services, be supported by public policy, and coordinate with any home visitation and other services aimed at parents of young children. PATHS and *Keys to CareGiving* are considered model programs. **Activities:** • Parent education classes. • Individual parent education. • Enhancement of skills in child communication, limit-setting, feeding and nutrition, child health, etc. • Enhance child abuse prevention efforts.
Prioritized Need 3) Public awareness and social change **Goal:** To change community norms to increase the appreciation for the importance of young childhood to human and social development. **Objective:** • To increase the awareness of the community regarding the targeted education, child care, and health-related issues (within 2 years).	**Indicators:** • Increased media coverage of child-related issues. • Increased media activity promoting positive child development, health, and wellbeing. **Outcomes:** • Decreased rate of home injuries to young children. • Decreased rate of child abuse and neglect. • Increased rate of use of existing services and programs.	**Strategies**: • Social marketing campaigns may utilize media (e.g., television, radio, print, billboards, etc.) to raise awareness and change social and community norms. **Activities:** • Community education and community organizing. • Public relations. • Advertising.

Strategic Plan Summary Table

PARENT EDUCATION AND SUPPORT (continued)

Prioritized Needs & Goals and Objectives	Indicators & Outcomes	Strategies & Activities
Prioritized Need 4) Literacy materials **Goal:** To increase the readiness of young children to learn to read. **Objective:** • To increase by at least 500 the number of books available in each region of the county to parents and literacy programs (within one year of the implementation of strategies and activities).	**Indicators:** • Increased number of reading programs. • Increased number of children's books loaned to parents by libraries and literacy programs. **Outcomes:** • Increased number of parents reading to their children. • Increased number of children entering kindergarten who are reading ready. • Increased reading scores on SAT-9 tests in elementary grades.	**Strategies**: • Increase reading out loud to children by increasing the availability of books and other materials. **Activities:** • Purchasing books for libraries, child care facilities, preschools, parks, and other venues for families of young children.

CHILD CARE AND EARLY EDUCATION

Prioritized Needs & Goals and Objectives	Indicators & Outcomes	Strategies & Activities
Prioritized Need 1) Stable and well-trained child care workforce **Goal:** To increase salaries, support, and educational opportunities for child care providers. **Objectives:** • To have at least 50% of local child care providers join the state-wide (child development permit) matrix (within 2 years of implementation). • To increase the average pay of all child care workers. • To have all Master Teacher-level providers receive at least the local self-sufficiency wages and benefits. • To have at least 15% of young children in licensed child care to be cared for in accredited programs (within 2 years of implementation).	**Indicators:** • Increased number and quality of mentoring and networking opportunities for providers. • Establishment of an incentive/compensation program linked to levels of training and professional experience. • Increased amount of accessible information on accreditation. • Increased incentives linked to accreditation in both family and center-based providers. • Increased number of licensed programs. • Increased skill level in licensed and licensed-exempt providers. **Outcomes:** • Increased number of licensed child care slots for young children. • Decreased turnover rate in child care staff.	**Strategies**: • Increasing the number of training opportunities including mentoring; educating, encouraging, and/or subsidizing child care providers to achieve accreditation; increasing the pay for child care workers; developing low-cost transportation for providers to get to training; expanding training to license-exempt providers; and advocacy. **Activities:** • Regular training programs. • Connection of pay increases to training level. • Subsidies for training and for accreditation. • Classes and/or workshops on accreditation.
Prioritized Need 2) Expanded child care services **Goal:** To develop a wide range of child care services for young children that are available 24-hours per day, seven days per week. **Objectives:** • To establish licensed child care programs for young children during nontraditional hours (i.e., other than 7 AM to 6 PM). • To increase the number of licensed child care programs whose staff are trained to provide care for children with special needs, including those at risk of child abuse and neglect, by at least 10% (within 2 years).	**Indicators:** • Increased number of licensed child care slots during nontraditional hours. • Increased number of licensed child care slots for children with special needs, including those at risk for child abuse. **Outcomes:** • Increased employment of parents. • Increased academic performance in elementary school grades. • Increased placement of special needs children in mainstream school environments.	**Strategies**: • Services could be expanded through funding, education, measurement of need and utilization of market forces, and advocacy. **Activities:** • Subsidies for providers to offer expanded hours. • Market analysis to inform providers of unmet needs. • Training for providers in nontraditional hours. • Training for providers in services to infants and toddlers and children with special needs.

Strategic Plan Summary Table

CHILD CARE AND EARLY EDUCATION (continued)

Prioritized Needs & Goals and Objectives	Indicators & Outcomes	Strategies & Activities
Prioritized Need 3) Universal preschool for children, ages three to five, pilot project **Goal:** To develop and implement a pilot project to demonstrate the effectiveness of preschool programs for children ages 3 to 5 years. **Objective:** • To establish at least one full-day, full-year preschool demonstration project (e.g., Head Start, State Preschool, Montessori, or church-based).	**Indicators:** • Increased number of eligible children participating in programs. • Increased number of children in licensed preschool programs. • Increased parental involvement in preschool programs. **Outcomes:** • Increased rate of school readiness and school attendance. • Increased academic performance in elementary school. • Decreased behavior problems in preschool programs. • Increased social ability and tolerance for diversity.	**Strategies**: • Development of a pilot program for full-day, full-year preschool for children 3 to 5 years of age; and advocacy for expanded state funding. **Activities:** • Subsidies for development of a pilot program. • Raise awareness in parents of the importance in developing cognitive skills in young children.

HEALTH AND WELLBEING OF CHILDREN

Prioritized Needs & Goals and Objectives	Indicators & Outcomes	Strategies & Activities
Prioritized Need 1) Fluoridation of drinking water **Goal:** To prevent tooth decay and other dental health problems in young children through the fluoridation of municipal and other public water supplies. **Objectives:** • To raise public awareness of the benefits of fluoridation and the lack of its harmful effects. • To fluoridate at least seven public water supplies (within 2 years of implementation of strategies and activities).	**Indicators:** • Policy statements by municipalities and water agencies of their intention to fluoridate drinking water supplies. • Development of local partnerships to advocate for and contribute to the costs of fluoridation. • Purchase and installation of fluoridation systems. **Outcomes:** • Reduced dental caries in young children. • Reduced dental disease in young children. • Increased nutritional health in young children.	**Strategies**: • Initial political and fiscal outlay to gain support of each public water source for fluoridation; gather funding, purchase, and install equipment; and then small annual cost of fluoride and maintenance. **Activities:** • Raise public awareness. • Development of political and economic support. • Development of maintenance agreements. • Installation of equipment. • Ongoing maintenance.
Prioritized Need 2) In-home visitation and support **Goal:** To improve child health through the establishment of an in-home visitation program for parents of newborns and infants. **Objective:** • To make in-home visits by qualified personnel to provide early identification of problems and developmental delays, monitor immunizations, promote smoke-free homes and tobacco cessation, teach and support parents in promoting health and wellbeing of their children, and make referrals to existing programs and services for health needs including parental substance abuse and mental health issues (within 2 years).	**Indicators:** • Increased rate of complete immunizations. • Increased knowledge of parents in subjects such as nutrition, illness prevention, and health promotion. • Decreased level of second-hand smoke in homes. • Increased rate of participation in health programs and services. **Outcomes:** • Decreased onset of serious developmental disorders. • Decreased chronic and acute childhood illnesses. • Increased indices of child health. • Decreased rates of child asthma and other smoking-related illnesses.	**Strategies**: • Home visitation program to pregnant mothers, or to families in their homes after discharge. Both the Cal SAHF and Hawaii models are considered models. **Activities:** • Information on existing programs and services. • Education on health, parenting skills, nutrition, etc. • Screening and referrals for developmental disorders. • Screening and referrals for postpartum depression. • Smoking prevention, education, and cessation. • See also Need #1 under the Parent Education and Support Focus Area for other in-home activities.

Strategic Plan Summary Table

HEALTH AND WELLBEING OF CHILDREN (continued)

Prioritized Needs & Goals and Objectives	Indicators & Outcomes	Strategies & Activities
Prioritized Need 3) Tobacco cessation for pregnant mothers and parents of young children **Goal:** To reduce second-hand smoke in homes and cars with young children. **Objectives:** • To reduce smoking by pregnant women and parents of newborns by at least 50% (within 2 years of implementation). • To provide smoking cessation services to all pregnant women and parents of young children who request such services.	**Indicators:** • Increased number of smoking cessation educational materials, classes, and counseling sessions. • Increased number of parents involved in cessation activities. • Increased number of parents committed to smoke-free homes and cars when children are present. **Outcomes:** • Decreased exposure of children to second-hand tobacco smoke. • Decreased incidence of child asthma and other smoking-related disorders.	**Strategies**: • Education; social marketing; advocacy; and cessation services. **Activities:** • Raise parental awareness through education. • Provision of cessation services. • Individual counseling. • Cessation classes. • Smoke-free pledges. • In-home advocacy for smoke-free homes and cars.
Prioritized Need 4) Dental preventive and restorative care **Goal:** To improve dental health in young children through prevention and treatment. **Objectives:** • To provide dental health education to at least 50% of the parents of young children (within 2 years of implementation). • To provide dental sealant treatments to at least 25% of young children from MediCal-eligible families or families without health care coverage (within 2 years of implementation of strategies and activities). • To augment funding for dental visits for children from MediCal-eligible families or families without health care coverage.	**Indicators:** • Increased number of parents receiving dental hygiene education. • Increased number of children receiving dental sealant treatments. • Increased number of children receiving dental care. **Outcomes:** • Decreased rate of caries in young children. • Increased dental health in children. • Increased nutritional level and general health in children.	**Strategies**: • Provision of services; education; and advocacy for public and provider policy change. **Activities:** • Subsidies for providers. • Augment existing low/no-cost programs. • Advocacy for public funding (e.g., through Healthy Families Program, increased MediCal reimbursement). • Advocacy for reduced-fee/pro bono work by providers.
Prioritized Need 5) Screening for developmental problems and sensory deficits **Goal:** To increase early identification and treatment of young children with developmental disorders and sensory deficits. **Objectives:** • To increase by at least 35% the number of young children with developmental disorders that are identified and treated (within 2 years of implementation of strategies and activities). • To provide counseling and treatment for families with young children with developmental disorders.	**Indicators:** • Decreased age of first entry into programs for children with special needs. • Increased number of children in programs for special needs. • Increased number and type of interventions available for children with developmental disorders and their families. **Outcomes:** • Increased academic performance in children with special needs. • Increased number of children with special needs attending mainstream schools. • Increased acceptance and understanding of children with developmental disorders.	**Strategies**: • Education; training; screening and early identification; prevention; and treatment. **Activities:** • Education for parents regarding signs and symptoms. • Training for providers to recognize signs and symptoms, including those disabilities which are difficult to diagnose. • Screening and referrals through home/hospital visitation program. • Increase use of existing screening programs.

Strategic Plan Summary Table

HEALTH AND WELLBEING OF CHILDREN (continued)

Prioritized Needs & Goals and Objectives	Indicators & Outcomes	Strategies & Activities
Prioritized Need 6) Postpartum depression **Goal:** To provide early identification and treatment for women who encounter depression after childbirth. **Objective:** • To expand accessibility of screening, treatment, and referrals for mental health services to mothers who experience postpartum depression.	**Indicators:** • Increased number of new mothers screened for depression. • Increased number of mothers receiving mental health services. • Increased sense of closeness between mother and child. **Outcomes:** • Increased health and wellbeing of children whose mothers experience postpartum depression. • Reduction in the rate of child abuse and neglect.	**Strategies**: • Education; training; prevention; and treatment. **Activities:** • Education for parents regarding signs and symptoms. • Training for providers to recognize signs & symptoms. • Screening & referrals through visitation program. • Expansion of treatment options. • Advocacy for expanded services.
Prioritized Need 7) Perinatal and young family alcohol and other drug abuse **Goal:** To prevent and treat alcohol and other drug abuse by pregnant women and parents of young children. **Objective:** • To provide alcohol and other drug prevention and treatment services to all parents who request them.	**Indicators:** • Increased number of alcohol and drug prevention classes. • Increased number of cessation and treatment groups. • Increased number of parents involved in treatment groups. **Outcomes:** • Increased health and wellness of children in families with parents in prevention classes and treatment groups. • Decreased incidence of child abuse and neglect. • Decreased incidence of domestic violence and other crimes.	**Strategies**: • Education; training; prevention; and treatment. **Activities:** • Education for parents regarding signs and symptoms. • Training for providers to recognize signs & symptoms. • Screening and referrals through visitation program. • Expansion of treatment options. • Advocacy for expanded services.
Prioritized Need 8) Comprehensive health care for young children **Goal:** To increase the number of families with young children who have a regular primary care provider, and who have increased access to comprehensive health care. **Objective:** • To expand the number of comprehensive pediatric sites that provide health care services, education, developmental assessment, social worker services, and nutritional education.	**Indicators:** • Increased number of families making regular visits to a primary care provider and comprehensive pediatric sites. • Increased availability of psychological, nutritional, and screening services. **Outcomes:** • Increased child health. • Reduction in the incidence of chronic and acute childhood illnesses and disorders and emergency room visits.	**Strategies**: • Education; social marketing; increase use of existing programs; and advocacy for expanded services and programs. **Activities:** • Raise public awareness of needs and benefits. • Augmentation of existing services. • Utilization of home/hospital visitation program. • Advocacy for expanded public funding.
Prioritized Need 9) Enrollment in existing health care programs **Goal:** To improve access to health care for those families of young children who are without coverage. **Objective:** • To increase enrollment of eligible families in the Healthy Families Program, Medi-Cal, and WIC.	**Indicators:** • Increased awareness of CBOs and health care providers. • Increased number of employers who assist with HFP premiums for low-wage workers. **Outcomes:** • Increased health in young children from low-income families. • Decreased rates of chronic and acute illnesses in young children from low-income families.	**Strategies**: • Education; social marketing; increase enrollment in existing programs; and advocacy. **Activities:** • Raise public awareness of programs and benefits. • Training for providers in eligibility, and application. • Advocacy for easier forms and application procedures.

ACKNOWLEDGMENTS

It takes a village to raise a child.
African proverb

This Strategic Plan was produced through the time, dedication, and hard work of a great many people and a number of organizations throughout San Luis Obispo County. A partial list of them follows:

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Chair: K. H. (Katcho) Katcho Achadjian
Vice-Chair: Elizabeth (Biz) Steinberg
Julian Crocker
Ellen Harper
Stephen Hansen
Debby Jeter
Laura King
Julia Miller
Gregory Thomas

Commission Staff:
Susan K. Hughes, Director
Christine Burkett
Jeff Hamm
Deb Hossli
Pam Ray
Season Conlan

Planning Consultant and Author:
Thomas Keifer

Advertising/Media Consultant:
Tom Jones

Webmaster:
ShowTel

Legal Counsel:
Warren Jensen

San Luis Obispo County Board of Supervisors:

Chair: Peg Pinard
Vice-Chair: K. H. (Katcho) Achadjian
Shirley Bianchi
Harry Ovitt
Michael Ryan

Facilitators/Consultants:
Jean DeCosta
Christine Enyart
Marcy Villa
David Tuohey-Mote

SLO County Risk Management:
Art Giumini

Translators:
Sharon Bruce: DSS
Mark Plants
Griselda Morales
Chris Haggie
Diana Rincon
Angela Sanchez
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Child Care Planning Council
SLO County Child Care Profile
State Pre-Schools
Tri-Counties Regional Center
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TABLE OF CONTENTS

		page
	Executive Summary	i
	Acknowledgements	ix
	Table of Contents	xi
I.	Vision and Mission Statements	1
II.	Guiding Principles	2
III.	Introduction to the Strategic Plan	3
IV.	Introduction to the Commission	5
	A. Background	5
	B. Membership	5
	C. Organization	6
	D. Staffing	7
V.	San Luis Obispo County - A Brief Overview	9
	A. Geography	9
	B. Population and Demographics	10
	C. Culture and Economics	11
VI.	Strategic Planning Process	13
	A. Purpose	13
	B. Coordination and Collaboration in Planning	14
	C. Research into Indicators of Need and Existing Services	15
	D. Community Input into Need	16
	E. Commission Strategic Planning Meetings	17
	F. Community Input on the Draft Strategic Plan	17
VII.	Needs Assessment Results	19
	A. Parent Education and Support Services	19
	B. Childcare and Early Education	22
	C. Health and Wellbeing of Children	24
VIII.	Goals and Objectives	27
	A. Parent Education and Support Services	27
	B. Childcare and Early Education	29
	C. Health and Wellbeing of Children	31

		page
IX.	Strategies and Activities	37
	A. Parent Education and Support Services	37
	B. Childcare and Early Education	38
	C. Health and Wellbeing of Children	39
X.	Resource Allocation	43
	A. Timeline and Budget	43
	B. Allocation Process	45
XI.	Evaluation	47
	A. Statement of Commitment to Ongoing Evaluation	47
	B. Evaluation of Planning Process	47
	C. Evaluation of Commission Activities	48
XII.	Appendices	51
	A. Community Analysis Report	51
	B. SLO County Children's Services Network Matrix of Services	69
	C. Community Meeting and Focus Group Summary	77
	D. Community Meeting and Focus Group Comments	99
	E. Community Meeting Evaluation Report	109

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- Ensure positive outcomes for children and their families by evaluating program impacts on children and families.
- Support efforts to maintain program services and research by leveraging and/or obtaining additional matching grant funds for program enhancement and sustainability.
- Support access to services for all families in an environment of support and respect.
- Encourage and support the development of each community's capacity to provide integrated services.

III. INTRODUCTION TO THE STRATEGIC PLAN

Unless the investment in children is made,
all of humanity's most fundamental long-term problems
will remain fundamental long-term problems.
The State of the World's Children, UNICEF, 1995

This Strategic Plan represents an emerging vision for a comprehensive and integrated system of prevention and early intervention services for children ages zero to five and their families. It also presents the outline of a plan to implement new and innovative programming to meet the unmet needs of this important group of people.

Young childhood is a critically important period of time. The experiences young children have, and the conditions in which they live, greatly influence the kinds of adults they will become. In ways that science is just now beginning to understand, and that our society is not even close to acknowledging, intellect, emotions, social interaction, and physicality in adulthood are intimately linked with childhood development. Deprivation at an early age, even conditions in the womb, can substantially, perhaps irreversibly retard development, and, therefore, can affect a person's entire life.

A young child's brain is developing rapidly, more so than at any other time in life. It is much more dependent upon, and, therefore, more vulnerable to, environmental influence than previously was thought possible. Nutrition, stimulation, and attention can affect not only the number of brain cells and connections, but also the structure of the neural connections themselves. The effects of the early environment on a young child's brain are long lasting, and can affect not only cognition, but also emotional and social adjustment and physical abilities and characteristics.

Likewise, early contact with caretakers, nutrition and health care, educational preparation, and family are intertwined into a complex system which can either support healthy growth and development or retard them. In many ways, conception to age five may be the most important time in human development. Yet, paradoxically, no time in a person's life has traditionally received so little attention from policy makers and other leaders as young childhood.

The Carnegie Task Force on Meeting the Needs of Young Children called it the *Quiet Crisis*. Their 1994 report, *Starting Points*, stated that a substantial number of children confront one or more of the following risk factors: inadequate prenatal care, isolated parents, substandard child care, poverty, and insufficient attention. Their conclusion is that these and other factors threaten both our children's and our nation's well being.

From substance abuse to teen pregnancy and from failing schools to violent crime, many of the social and health problems facing our society may be traced to the risk factors

cited by the Carnegie Task Force. Yet, as their report notes, there are no clearly defined institutions such as universal child care or preschool to serve young children and their families. Health, educational, and social service agencies often work without coordination, and sometimes act in ways which are counter productive. And young children and their families are caught in the middle.

Young people in San Luis Obispo (SLO) County are no less at risk for the bucolic nature of our rural area. They face poverty, inadequate prenatal care, parental isolation and lack of training, and substandard child care just like young children in urbanized areas. The sheer numbers may not be as great, but many of the rates for these risk factors are as high or higher than those in the big cities.

In developing this Strategic Plan the Children and Families Commission of San Luis Obispo County has acted on the premise that parents are the most important resources in early childhood development. Although a diverse range of individuals and organizations impacts the health and wellbeing of children, the role of parents is paramount, even more so during the crucial years of zero to five. All of the activities of the Commission are intended to assist parents in providing a safe, nurturing, and stimulating environment for all of our children.

The following sections describe: the origins and structure of the Commission; the strategic planning process; the needs of young children and their parents in San Luis Obispo County; existing services and gaps in those services; the priorities, goals, objectives, and allocation process by which the Commission will use its resources to leverage existing services in order to expand the capacity of our communities to serve young children and their families; and the indicators, outcomes, and evaluation procedures that will be used to track the success of the activities.

The Commission plans to be active in achieving its vision in three ways: 1) Allocation of funds available to the Commission through Proposition 10; 2) Advocacy for expanded funding from other sources; and 3) Increasing public and institutional awareness of the importance of early childhood development, and advocating for policies supportive of young children and their families. Through these three *Phases of Action* the Commission intends to work collaboratively with service providers, community representatives, and other SLO County planning groups to help develop a consumer-oriented comprehensive system of integrated services that are easily accessible to parents and young children. The Commission fully realizes the scope of the task. The vision is ambitious, and will take a number of years to implement.

The Strategic Plan as currently configured will undoubtedly go through a number of revisions; some of them, perhaps, significant. The Commission intends to review the plan annually, at a minimum. This document is a work in progress. With the continuing and considerable involvement of the community, the Strategic Plan will continue to evolve as long as the Children and Families Commission of San Luis Obispo County is in operation.

IV. INTRODUCTION TO THE COMMISSION

Let us put our heads together,
and see what life we shall make for our children.
Sitting Bull

A. BACKGROUND

The California Children and Families First Act of 1998 (Proposition 10) established a system for the development of strategies and activities to serve children, five years of age and under, and their families. Through health care, quality child care, parent education and support, and effective prevention and intervention programs, the Act was designed to help families and other caregivers acquire the resources necessary to foster healthy and successful development, and to build individual, familial, and community assets that can act to ameliorate risk factors such as poverty, violence, and isolation.

The Children and Families Commission of San Luis Obispo County was convened to explore San Luis Obispo County's needs, strengths, and options by developing a comprehensive Strategic Plan to meet the significant needs of our young children and their parents. The goals of the strategic planning process were: 1) to support parents in building their capacities to provide a nurturing and safe environment; 2) to assure the availability of sufficient high quality child care; and 3) to provide all young children with the opportunity to reach their school years healthy, nurtured, and prepared to succeed. The Commission intends to serve as an organizational infrastructure to assess the need for, and to institutionalize, systems change, programs, services, and resources to ensure that our community meets these goals.

B. MEMBERSHIP

The Children and Families Commission of San Luis Obispo County is made of up nine representatives appointed by the County's Board of Supervisors from communities throughout the county. Their backgrounds span the range of children's services, including education, health care, social services, child care, public and private service organizations, and local government.

The membership of the Commission is as follows:

K. H. Achadjian
Designated Representative (Chair)
Supervisor, 4th District, County Board of Supervisors
Two-year term (4/01)

Julian Crocker
Designated Representative
County Superintendent of Schools
Two-year term (4/01)

Membership of the Commission (continued):

Stephen Hansen
Designated Representative
SLO County Medical Society
Four-year Term (7/03)

Debby Jeter
Designated Representative
Acting Director, Department of Social Services, County of SLO
Two-year Term (4/01)

Julia Miller
Designated Representative
Coordinator, SLO County Children's Services Network
Four-year Term (9/03)

Gregory Thomas
Designated Representative
Health Officer, Health Agency Director, County of SLO
Two-year Term (4/01)

Ellen Harper
Representative At-large
Retired School Nurse
Four-year Term (7/03)

Laura King
Representative At-large
Associate Professor of Psychology, California Polytechnic State University
Four-year Term (7/03)

Elizabeth Steinberg
Designated Representative (Vice-Chair)
Chairperson, SLO Child Care Planning Council
Four-year Term (4/03)

Seven of the commissioners were appointed by the Board of Supervisors as designated by the requirements of the Act. Two were selected by the Board as at-large representatives from the community. Commissioners serve a four-year term, though initial terms were staggered to assure continuity of membership.

All nine commissioners have dedicated themselves to a rigorous and comprehensive needs assessment and strategic planning process. Their overriding goal has been to establish a means whereby comprehensive and integrated services may be developed which will assist parents in laying the emotional, physical, and intellectual foundation for every child to enter school ready to learn and to fully realize his/her potential to become a successful, fulfilled, and productive member of our community. The commissioners take their mission seriously, and they have worked hard to put it into practice.

C. ORGANIZATION

The Children and Families Commission of San Luis Obispo County is an independent public body. Its charge is to promote the health and well-being of young children and their families, to improve developmental outcomes for children, and to help them grow to their fullest potential. The Commission intends to support delivery at the local level

of a wide range of programs and services to help families and communities support their children, ages zero to five.

The Commission has adopted an interim structure utilizing the County of San Luis Obispo as an organizational infrastructure. The County provides fiscal and accounting services, insurance, legal advise, and staffing for the Commission. All decision-making by the Commission, as well as day-to-day operations, are autonomous from the County.

This is described as an interim structure, because the Commission considers its paramount task to be the development of its Strategic Plan, and the implementation of programming to serve young children and their families. The question of the ultimate structure of the Commission (e.g., continued alignment with the County, affiliation with an existing private nonprofit, or complete independence as a private nonprofit) have been postponed until the critical first step is completed, and new programming is well under way.

D. STAFFING

The Children and Families Commission of San Luis Obispo County is staffed through a contract with the Public Health Department of the County of San Luis Obispo. Staff support is currently provided through two positions which operate under the umbrella of the SLO County Tobacco Control Program. These positions are: 1) a half-time Director; and 2) a "limited term" permanent full-time Senior Typist Clerk position. Clerical support is provided through the SLO County Tobacco Control Program.

Consultants have been hired to provide support in the following ways: research into and compilation of needs assessment data, facilitation of public planning meetings, and composition of the Strategic Plan.

IV. SAN LUIS OBISPO COUNTY - A Brief Overview

A. GEOGRAPHY

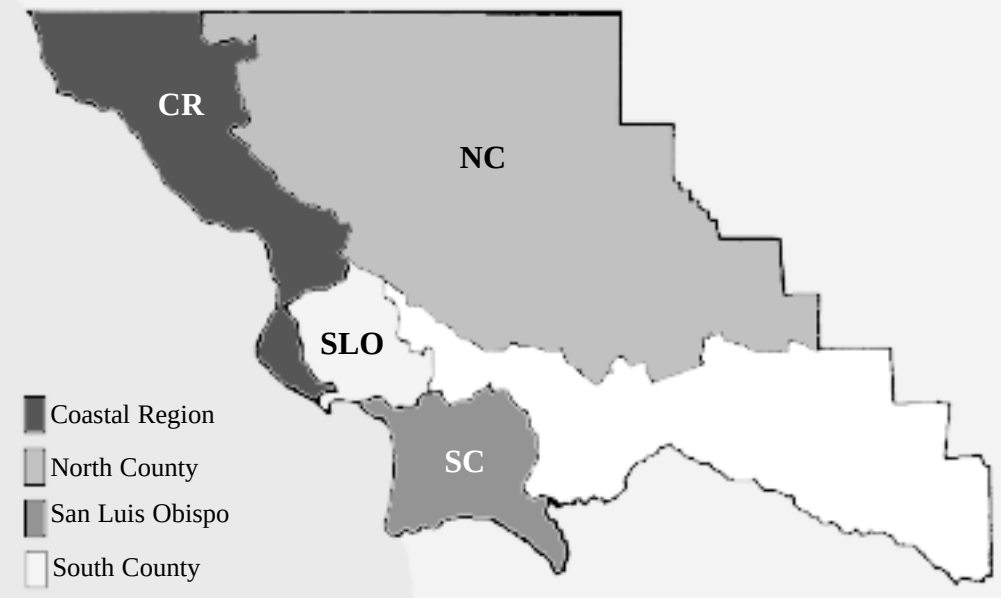
San Luis Obispo (SLO) County is the fifteenth largest county in California. Covering 3,316 square miles, this largely rural county lays between the Pacific Ocean and the Santa Lucia coastal mountains, mid-way between Los Angeles and the Bay Area. On the north the county is bordered by Monterey County. The Eastern boundary is the Kern County line. To the south is Santa Barbara County, and the Western edge is the Pacific Ocean.

Much of the county is unpopulated, covered by agriculture, wild mountains, or coastal plains. Most of it, over 98% of the landmass, is unincorporated. Forty-one percent of the population lives in unincorporated areas.

The climate is moderate along the coast. The annual rainfall in the county is 22 inches. In the City of San Luis Obispo the mean annual temperature is 54° Fahrenheit. Inland the temperature is higher, and the rainfall is lower. During the summer months the temperature may be as much as 40° cooler along the coast than inland.

San Luis Obispo County is prototypical of many other rural areas across California and the nation. It is divided into four distinct population/geographic regions: North County, Coastal Region, San Luis Obispo, and South County (see Figure 1).

Figure 1
Regions in San Luis Obispo County



While joined together in one county, these four regions view themselves as having unique populations, identities, and needs. There is occasional regional competition and resentment. There can also be a lack of coordination between organizations and agencies between (and within) regions.

One implication for educational, health, and social service programs of this regional character is that activities or approaches that work in one region may not work in another. This makes regional collaboration an absolute necessity so that:1) a general strategy may emerge; 2) specific interventions may be designed within that strategy which work for specific localities; and 3) resources within the county may be maximized.

B. POPULATION AND DEMOGRAPHICS

In San Luis Obispo County much of the population (237,034 according to the *1998 U.S. Census Update*) is in distinct clusters along U.S. 101, the major north-south highway through the County. There are seven incorporated cities in the County with 59% of the County's residents. None of these cities are larger than 50,000 people, and most are closer to 10,000. The rest of the population (41%) is spread throughout the county, resulting in a population density of just 69 persons per square mile.

Another implication of the rural character of SLO County is the distribution of the population throughout the coastal corridor (the white section in the bottom left-hand corner of Figure 1 is essentially unpopulated territory, as is much of the Eastern portion of the North County region). The County Seat, San Luis Obispo, is 40 miles (or more) from some communities in the county, and while some services are available in outlying areas, others are not. Availability and accessibility can be significant issues for families in obtaining services for their children, as public transportation, especially in outlying areas in the county, is inadequate.

Ethnically, the population of SLO County (according to the *1998 U.S. Census Update*) breaks down in this manner:

African American	3%
Asian/Pacific Islander	3%
Hispanic	17%
Native American	1%
White	76%

As in the rest of California, the Hispanic population is rising rapidly in SLO County. Between 1980 and 1990 the number of Hispanic residents in the county grew by 82% – and the reported rate is generally considered to be low due to the immigration status of many people. The percentage of Hispanic residents is higher in some regions of the county; in Oceano and Nipomo in the South County, they make up over one-third of the population, and in the North County Hispanics are 25% of the population.

Demographic changes are accelerating. The percentage of Hispanic children in SLO County is higher than for all Hispanics - 21% in 1998. For those birth to five years old, the figure was 26%. Throughout the county, Hispanic residents constitute a disproportionately high number of the poor, and many Hispanic young children live with significant risk factors.

The county is one of the fastest growing in California. Population projections for the next few year are for 2% growth per year, such that between the years 1995 to 2020 the county growth is expected to be more than 40%, or about the same as that for the years 1980 through 1990. Too much or poorly planned growth was the one thing which most detracted from the quality of life for parents of young children (14%).

The juvenile population of San Luis Obispo County has been growing rapidly, too, increasing 34% between 1990 and 1998. The population of children under five years old grew by 51%. There are currently 46,425 children under the age of 14 in the county. This trend is expected to continue, with the juvenile population exceeding 55,000 by 2005, a 64% increase over 1990.

C. CULTURE AND ECONOMICS

Statistics from the U.S. Census indicate that SLO County is relatively well educated. One quarter of the population 25 years old and over had a high school diploma. About the same proportion (23%) had a four-year college degree.

The average class size in SLO County schools was slightly less in 1998 than in the state as a whole (25.6 to 27.2). The school drop-out rate in SLO County (1.5%) was lower in 1997/98 than the state rate of 2.9%.

SLO County students consistently fare better than their state peers in academic achievement such as the Stanford Achievement Test (e.g., 1998 fourth-grade reading scores in the county were 629 versus 614 in the state and the math scores were 650 to 627, respectively). Children in the third grade read and did math at, or better than the national average, 68% of the time in 1999, higher than the state levels of 53% and 56%.

The economy in SLO County mirrored the rest of the nation in 1999. Unemployment was a low 3.0% in December, 1999, lower than the state rate of 4.6%. According to the *1998 U.S. Census Update*, the civilian labor force in SLO County grew 53% between 1980 and 1990, to 102,797. Just under half (45%) were women.

San Luis Obispo County is a good place to grow up. It is ranked eighth (out of 58) in the state's counties in indicators of young-child wellbeing. Not everything is idyllic in SLO County, however.

Retail sales, the service industry, and agriculture, all relatively low paying jobs, dominate employment in SLO County, resulting in a large number of working poor. In fact,

the median household income for the county ($35,683 in 1998) is lower than the state as a whole. Fifteen percent of the population live below the Federal Poverty Level, higher than the state average. Thirty percent of the population are at or under 200% of the poverty level. The same proportion (30%) in the county receive some form of welfare and/or public aid.

There were 52,703 households in SLO County in 1990, a 34% increase over the previous decade. Slightly over half (55%) of the family households had two working parents. Twenty percent of the households in the county are headed by a single parent. More than one-third of these families (36%) live under the poverty level. Eighty-two percent of the single-parent households are headed by women, and almost 40% of them live under the poverty level.

Sixty percent of the households lived in a home they owned in 1990. But, while the county population continues to grow, only 1,200 houses were built last year. Vacancy rates are at record low levels, and the median rent has increased 25% in the last nine years. The area is the eighth-ranked least affordable in the nation for housing.

VI. STRATEGIC PLANNING PROCESS

Think not forever of yourselves, O Chiefs, nor of your own generation.
Think of continuing generations of our families,
think of our grandchildren and of those yet unborn.

Peacemaker, founder of the Iroquois Confederacy

A. PURPOSE

The mandate for local commissions from the California Children and Families First Act of 1998 is:

> *to facilitate the creation of a seamless system of integrated and comprehensive programs and services, and to develop a funding base for the system with program and financial accountability, that will establish community-based programs to provide parental education and family support services relevant to effective childhood development. These services include education and skills training in nurturing and in avoidance of tobacco, drugs, and alcohol during pregnancy. Emphasis is on services not provided by existing programs and on the consolidation of existing programs and new services into an integrated system from the consumer's perspective.*

The following three *Focus Areas* for these efforts were identified by the Act:

1) **Parent Education and Support Services** in all areas required for, and relevant to, informed and healthy parenting. Examples of parent education shall include, but are not limited to, prenatal and postnatal infant and maternal nutrition, education and training in newborn and infant care and nurturing for optimal early childhood development, parenting and other necessary skills, child abuse prevention, and avoidance of tobacco, drugs, and alcohol during pregnancy. Examples of parental support services shall include, but are not limited to, family support centers offering an integrated system of services required for the development and maintenance of self-sufficiency, domestic violence prevention and treatment, tobacco and other substance abuse control and treatment, voluntary intervention for families at risk, and such other prevention and family services and counseling critical to successful early childhood development.

2) **Child Care and Early Education** that is available, affordable, accessible, and of high quality. This care must be both in-home and at child care facilities, and must emphasize education, training and qualifications of care providers, increased availability and access to child care

facilities, resource and referral services, technical assistance for care-givers, and financial and other assistance to ensure appropriate child care for all households. It is important that every child reaches school ready to learn.

3) **Health and Wellbeing of Children** through the provision of services that emphasize prevention, diagnostic screenings, and treatment not covered by other programs. Also of critical importance is the provision of prenatal and postnatal maternal health care services that emphasize prevention, immunizations, nutrition, treatment of tobacco and other substance abuse, general health screenings, and treatment services not covered by other programs.

Local strategic plans are required, at a minimum, to include: a description of the goals and objectives proposed to be attained; a description of the programs, services, and projects proposed to be provided, sponsored, or facilitated; and a description of how measurable outcomes of such programs, services, and projects will be determined by the county commission using appropriate reliable indicators. No county strategic plan shall be deemed adequate or complete until and unless the plan describes how programs, services, and projects relating to early childhood development within the county will be integrated into a consumer-oriented and easily accessible system.

The Children and Families Commission of San Luis Obispo County prepared this Strategic Plan through four steps. First was initial research into indicators of need and existing services. Second came concerted efforts to solicit community input. Third, the Commission engaged in a thorough analysis and prioritization of needs and service gaps as well as the development of a plan and timeline for the allocation of funds available through the Children and Families Initiative. Finally, a second phase of public input was held regarding the draft Strategic Plan before its final adoption.

B. COORDINATION AND COLLABORATION IN PLANNING

There have been a number of planning initiatives ongoing in San Luis Obispo County during the past year. The United Way's *Success by Six* strategic planning process took place during 1999. It very closely paralleled the Commission's work, as it assessed needs, existing services, and gaps in service for children zero to six years. The *Success by Six* plan was completed in Fall, 1999, and the consortium applied successfully for funding from the United Way/Bank of America in order to implement a pilot home visit program for at-risk infants in the Coastal Region of SLO County.

The San Luis Obispo Child Care Planning Council has also been formulating its five-year Needs Assessment since Fall, 1999. Their emphasis is on child care for children ages birth to twelve years, but there is obvious overlap in missions between the Council and the Commission. The Council will be developing their strategic plan during the latter half of 2000.

Another recent development in the area of services to young children and their families is the successful application by the SLO County Public Health Department for a grant to serve medically vulnerable infants. The program will target infants from the county's Pediatric Intensive Care Unit with hospital and home visits designed to deliver a comprehensive and integrated system of care from birth to age three.

The Children and Families Commission of SLO County is committed to working collaboratively with these and other efforts to assess the needs of, and provide services to young children and their families. While timing issues have not necessarily allowed the groups to plan together, the legacy of collaboration and communication between agencies and organizations in San Luis Obispo County is one to which the Commission intends to adhere. The Commission will continue to work in partnership with other service agencies in order to avoid duplication of energies, and to assure that young children and their families benefit from all of the opportunities available to them.

C. RESEARCH INTO INDICATORS OF NEED AND EXISTING SERVICES

A preliminary step in the planning process was the compilation of statistics relating to need in the three Focus Areas. A consultant was hired to research and assemble data from a number of sources which could indicate the health, education, child care, and social and economic conditions of young children and their families. These data were presented to the Commission for their review in the *Community Analysis Report* which is appended to this document (see Appendix A).

The *Community Analysis Report* presents data from a wide range of sources which cover an even wider range of subjects. The data include demographic information such as population age distributions in the county, birth rates, ethnicity, and number of children living in poverty. Some examples of the indicators within the three Focus Areas are:

> **Parent Education and Support Services**: children and families living in poverty, number of families in WIC, teen birth rates, educational level of parents, literacy rates, level of early prenatal care, percentage of low-birth weight, foster care rates, and child-injury rates.
>
> **Child Care and Early Education**: percentage of children with working parents, number and capacity of child care providers, level of and need for provider training, availability of care during nontraditional hours, costs of child care, provider turnover rates, and need for specialized care.
>
> **Health and Wellness of Children**: access to quality health care, oral health, breastfeeding rates, immunization rates, rates of developmental delays, fetal exposure to alcohol and/or other drugs, levels of exposure of children to tobacco, and mental health needs.

The San Luis Obispo County Children's Services Network initiated an assessment of existing services available in San Luis Obispo County for young children and their families. This was an important step, in that it allowed the Commission a basis from which to identify gaps in the service delivery system. The resulting *Matrix of Services* is appended to this document (see Appendix B).

D. COMMUNITY INPUT INTO NEED

A critical component of the needs assessment was the solicitation of input from the community. Two different kinds of forums provided opportunities for the community to comment about community needs, service gaps, and the use of funds generated through the Children and Families First Act.

Members of the Commission and staff attended each of the meetings in each of the two forums. These two forums are summarized below, and in two documents, *Community Meeting and Focus Group Summary* and *Community Meeting and Focus Group Comments,* which are appended to this plan (see Appendices C and D, respectively).

1. Community Meetings

Eight community meetings were scheduled throughout San Luis Obispo County in January and February, 2000. Two meetings were held in the North County, and two were held in the Coastal Region. Three meetings were held in the South County, and one was conducted in San Luis Obispo.

A total of 153 parents, providers, and other community representatives attended the meetings. Each meeting was facilitated by a consultant, and included a presentation on the Children and Families First Initiative by the Commission's Director. The bulk of the meetings was given over to a discussion regarding the three Focus Areas and associated needs, services, gaps, and potential program initiatives.

2. Focus Groups

Four focus groups were held at child care sites in order to specifically target parents of young children. Seventy-two parents and child care providers attended the four meetings which were held in the North County, South County, and San Luis Obispo (2 meetings). The meetings were professionally facilitated by consultants. The participants were asked to comment on the three Focus Areas and associated needs, services, gaps, and potential program initiatives.

An informal evaluation of the community input stage was performed. A brief survey form was distributed at each community meeting and three of the four focus groups, and participants were asked to give their impressions of the utility of the meetings, level of understanding about the role of the Commission, and several other factors. The results, *Community Meeting Evaluation Report,* is appended to this document (see Appendix E).

E. COMMISSION STRATEGIC PLANNING MEETINGS

Realizing the scope of the planning process, the Commission scheduled time outside of their monthly business meetings in order to complete the Strategic Plan. Five four-hour meetings were held in March and April, 2000. All meetings were open to the public.

The strategic planning meetings allowed the Commissioners significant time to digest, discuss, and organize the information from the needs assessment process. The meetings were facilitated by a professional consultant, and attended by staff.

The structure of the meetings led the Commissioners through the following steps:

1) The Commissioners consolidated issues raised during the community input phase. After this step the staff paired the resulting needs in each of the three Focus Areas with data from the initial research phase.

2) The Commissioners used this information in order to prioritize the needs into the three Phases of Action: 1) direct funding of programs through monies from Proposition 10 ; 2) advocacy for funding through other sources; 3) raising community awareness, and advocacy for public and institutional policy change.

3) At this point the Commissioners generated goals, objectives, and suggested possible strategies and activities for each of these needs.

4) Finally, the Commissioners developed a strategy and timeline for the dissemination of its funds from the Children and Families First Initiative, and adopted a budget for funding that had been developed by the staff.

F. COMMUNITY INPUT ON THE DRAFT STRATEGIC PLAN

The final stage in the preparation of this document entailed a second round of community input. Upon completion of the draft Strategic Plan, 44,000 copies of the draft Executive Summary were printed, and distributed throughout the county in a number of ways, including: copies were mailed to professional youth service providers (e.g., health care, child care, preschools, etc.); copies were mailed to all community representatives who had taken part in the earlier community input stage of the planning process; an insert was placed in the county-wide daily newspaper; a Spanish-language version was distributed throughout the county by Hispanic service providers; and copies in both English and Spanish were left at all city and county libraries.

Four Public Forums were held to solicit input from the community on the draft Strategic Plan. Three were held on June 20, 2000, one each in the North County, Coastal, and South County Regions. Commission members and staff attended each meeting. A final

Public Forum was scheduled as a full Commission meeting on June 21, 2000 in the San Luis Obispo County Board of Supervisors' Chambers. The meeting was televised live throughout the county on the local public access cable television channel. During this meeting the Commission solicited community input, made final decisions concerning the contents of the Strategic Plan, and voted for formal adoption of this document as their Strategic Plan for collaboratively developing a comprehensive system of integrated services for children, ages zero to five years old, and their families.

VII. NEEDS ASSESSMENT RESULTS

The family is one of nature's masterpieces.
George Santayana

As stated earlier, the Children and Families Commission of San Luis Obispo County plans to pursue achieving its vision through three Phases of Action:

1) Allocation of funds available to the Commission through the California Children and Families First Act (Proposition 10).
2) Advocacy for expanded funding from other sources.
3) Increasing public and institutional awareness of the importance of early childhood development, and advocating for policies supportive of young children and their families.

The following discussion presents a brief synopsis of the results of the needs assessment, along with the needs identified by the Commission as their priorities. These needs of young children and their families in San Luis Obispo County were prioritized within each of the three Focus Areas (Parent Education and Support, Child Care and Early Education, and Health and Wellbeing of Children) and within each of the three Phases of Action (Allocation of Funds through the Commission, Advocacy for Expanded Funding through Other Sources, and Increasing Awareness/Advocacy for Policy Change).

A. PARENT EDUCATION AND SUPPORT SERVICES

1. Synopsis of Data

Effective parenting starts at conception with proper diet and prenatal care. Parents who are poor, young, unmarried, less well educated, uninsured, or living in rural areas are less likely to receive appropriate prenatal care, and less likely to access available services as their children grow up.

San Luis Obispo County ranks 17th out of California's 58 counties in the percentage of children, zero to five years of age, living in poverty - 17% in SLO County versus 20% for the state mean.

One-in-ten children (10.8%) receives Temporary Assistance for Needy Families (TANF). Almost one-in-five children between birth and four (18%) receive Women, Infant, and Children (WIC) assistance. The county lags significantly behind the State average in number of eligible children who receive WIC assistance (49% to 68%, respectively), ranking in the bottom 10% of California counties.

Twenty percent of the families in the county are headed by a single parent. More than one-third (36%) of these families live under the poverty level. Eighty-two percent of the single-parent households are headed by a woman, and almost 40% of them of them live under the poverty level. Child support cases with court orders to comply composed 85% of the cases in the county, versus about half that (48%) in the state as whole.

Teen pregnancies are generally low in SLO County, occurring 27 times for every 1,000 teenage girls, versus 57 for California as a whole. But, communities in three of the four regions in SLO County have teen pregnancies at epidemic rates, and were designated as *Teen Pregnancy Hot Spots* by the California Department of Health Services. These Hot Spots are: Cambria in the Coastal Region, Paso Robles in the North County, and Oceano in the South County. Hispanic teenage girls represent a disproportionately high percentage of teen births in the county, accounting for 47% of the teen births in 1997, despite being about 22% of the population.

In San Luis Obispo County in 1996/97 one in five infants (20%) were born to mothers who received late or no prenatal care during their pregnancies. This percentage is slightly higher than the State as a whole. For women who are poor (as defined by Medi-Cal eligibility) the rate was more than doubled, or two in five (43%), in 1996.

Inadequate prenatal care (as identified by the Kessner Index) was received by one-quarter of the mothers in SLO County. National figures indicate that this rate is on the rise.

The numbers for perinatal substance abuse in SLO County are about the same as for the state as a whole, 11.9% to 11.1%, respectively. The exposure rate for tobacco and alcohol was higher for SLO County that the state (8% versus 7% for tobacco, and 10% versus 9% for alcohol, respectively).

Low birth weight was reported in 5.5% of the cases in 1997, as opposed to 6.1% in the state in the same year. Infant mortality occurs at about the same rate in the county (6.0) as the state average (5.9). Mothers initiate breastfeeding exclusively 82% of the time in SLO County as opposed to 43% of the time in the state.

One-fifth (20%) of the babies in SLO County are born to mothers who have less than a twelfth-grade education. This is significantly below the state mean of one-third (32%). An estimated 17% of the residents of San Luis Obispo County have a low literacy proficiency versus 46% for California as a whole.

Child abuse rates in SLO County in 1996 were significantly higher, almost twice as high as the State (149 to 78, respectively). This puts SLO County 46th out of the state's 58 counties.

San Luis Obispo County ranks at the state mean for injuries of young children (0 to 5) in motor vehicle accidents. In 1998/99, the rate (per 10,000) for such injuries in SLO

County was 21, while in the state as whole it was 22. While California averaged 0.26 deaths per 10,000 young children, in SLO County the rate was zero. A recent local check by the California Highway Patrol discovered that 82% of the infant care seats in automobiles in SLO County were incorrectly installed.

2. Prioritized Needs

The prioritized needs in this Focus Area are presented under the three Phases of Action:

Allocation of Funds through the Commission

1) **Prenatal and post-delivery education**: Services to meet this need would provide education and referrals on health, age-appropriate behavior, child abuse prevention, nutrition (including breastfeeding education, first foods, menu preparation, and easy-cooking hints), feeding techniques, tobacco use prevention aimed at pregnant mothers and parenting mothers and fathers, identifying and reacting to infant communication and needs, and developmental milestones.

2) **Parenting skills training:** Parenting may be the most important thing that people do, yet there is absolutely no structured training to give people the information or skills they need to do it well.

3) **Public awareness and social change**: The critical importance of young childhood experience and development must become widely understood and accepted. The inherent value of children, their health and wellbeing, and our shared responsibility to raise our future together must become a part of our social norms. Other objectives might be met concurrently through public awareness and social change activities (e.g., injury prevention, child abuse prevention, and increase awareness of available services).

4) **Literacy materials**: Services to meet this need would increase the number of books available to parents and to literacy and reading programs.

Advocacy for Expanded Funding through Other Sources

1) **Literacy programs**: Reading for pleasure is an important developmental asset. Services to meet this need would increase the availability of books, teach the skill of reading out loud, and provide opportunities for children to read and to be read to.

2) **Recreational, cultural, and artistic opportunities**: Many services such as *Mommy and Me*, library reading programs, and others are

offered at hours which make them unavailable to many parents. Services to meet this need would provide expanded hours and days (e.g., evenings and weekends) and scope (e.g., *Daddy and Me*) of such programs, as well as provide more stimulating materials and resources (e.g., toy lending library) for such programs.

Increasing Awareness/Advocacy for Policy Change

1) **Child abuse and neglect prevention and intervention training**: Teachers, child care providers, and others who interact with children should be offered local, documented training as part of certification, licensure, or accreditation, as well as for continuing education.

2a) **Carseat safety**: It is important to increase the number of people who are involved in ensuring the proper installation and use of carseats. Highway patrol, police, car salespersons, and car mechanics are some of the professions who should be trained for and encouraged to participate in increasing the proper installation and use of carseats.

2b) **Carseat safety**: Proper installation and use of carseats would be greatly facilitated by standardized carseat design. It is also important that manufacturers offer standardized built-in car seats on new cars.

B. CHILD CARE AND EARLY EDUCATION

1. Synopsis of Data

Many parents in San Luis Obispo County are in need of child care. Over half (55%) of the children ages five years or less live with working parents. About the same number (51%) are estimated to be in child care outside of the families. Both of these figures are comparable to state averages.

Overall there were 363 licensed child care facilities in San Luis Obispo County in 1999. In 1996 there were 404 such facilities, a decrease of 10% in three years. Yet the number of slots in licensed facilities has risen 14% in that same period, from 6,024 slots in 1996 to 6,872 in 1999. This ranks SLO County in the middle of California's 58 counties at number 25. It is estimated that licensed facilities can meet about 24% of the need for child care in the county.

There are four accredited licensed child care centers in the county. None of the licensed family care homes is accredited, although four were in the process of obtaining accreditation at the time this document was composed.

Regionally the availability of child care is as follows: North County - 2,245 slots, an increase of 32% since 1996; Coastal Region - 746 slots, an increase of 5% since 1996;

San Luis Obispo - 1,770 slots, a decrease of 3% since 1996; and South County - 1,931 slots, an increase of 16% since 1996. Thus, the North and South County regions have demonstrated solid growth in the number of slots, while San Luis Obispo and the Coastal Region have remained at essentially the same capacity in the past three years.

Slightly more than half (54%) of the parents surveyed need full-time child care. Most of the licensed preschools in the county can offer only half-day classes. While 13% of the parents need nontraditional hours (other than 7 AM to 6 PM, Monday through Friday) for child care, only 4% of the child care centers, and 28% of the licensed family care homes offer care during nontraditional hours.

Approximately equal number of parents need child care for infants/toddlers and preschool children (39% versus 36%, respectively). One percent of the slots in licensed child care centers are available for infants in SLO County, versus 4% in California.

Almost half (48%) of the children in the county who are eligible for Head Start are enrolled, putting SLO County in the middle of California's 58 counties at number 27. The county is at the state mean for the total proportion of children under 4 years of age who are enrolled in Head Start (3.2% in SLO and 3.3% in California).

The average cost for one child in child care in SLO County is approximately $104.50 per week, which translates into a mean monthly cost of $453, or an annual cost of $5,434. The median annual income in SLO County is $37,830. The care for one child in SLO County accounts for 14% of the annual income of a person earning the median income. The care for one child in SLO County accounts for 45% of the annual income of a person earning minimum wage ($11,960).

There is a significant annual turnover (30%) of staff at child care facilities in SLO County. The median income for a child care worker in the county ranges from $584 per month, or $7,010 annually, to $1,352 per month, or $16,224 per year.

2. Prioritized Needs

The prioritized needs in this Focus Area are:

Allocation of Funds through the Commission

1) **Stable and well-trained child care workforce**: Ensuring services to meet this need would include increasing skills, knowledge, and commitment of child care workers, both licensed and license-exempt. As well as general training, there is a need for training in care for children with special needs and for infants and toddlers.

2) **Expanded child care services**: Services to meet this need would provide child care for children from zero to five years during nontradition-

al hours (e.g., weekends, evenings, and on call) through providing safety and security evaluations, and offering pay incentives to open off-hours. Expanded services are also necessary for children with special needs, including those children at risk for child abuse and neglect.

3) **Universal preschool for children, ages three to five, pilot project:** Increasing readiness for Kindergarten and full-day child care are both critical needs. Services to meet this need would include an enhanced full-day, full-year preschool program.

Advocacy for Expanded Funding through Other Sources

1) **Suitable facilities**: Many areas in the county are without child care services for want of proper facilities. Services to meet this need should include support toward licensure and accreditation.

2) **Expanded range of child care providers**: Development of partnerships with other organizations (e.g., businesses and the faith community) could result in additional child care programs in areas of need.

Increasing Awareness/Advocacy for Policy Change

1) **Expanded affordable and accessible child care availability**: Appropriate institutional and public policies would result in child care availability for all families who needed them.

2) **Expansion of preschool:** Elementary schools could offer expanded preschool programs for four and five year-old children.

3) **Child care staff quality and stability**: As in other professions, child care workers get better with experience. Yet many leave the profession because of the low pay and few benefits. Increased wages and benefits for child care providers would greatly improve quality, availability, and stability of child care in our communities.

4) **Family leave**: Policies in our community must support parents with family leave when their children are born, injured, or ill.

C. HEALTH AND WELLBEING OF CHILDREN

1. Synopsis of Data

Almost two-thirds (63%) of the parents of children 5 years and under in SLO County are concerned about access to health care. Data indicate that families with at least one child, five-years or under, have less access to health care than SLO County as a whole.

One-third (31%) of the parents of children, five years and under, report that they have no health insurance, as opposed to only 15.5% of the general population. One-quarter (25%) report that they have no regular source for primary health care for their family, as opposed to only 18.3% of the county as a whole. Almost one-in-five (17.2%) report a family member needing health care in the prior year, but were unable to obtain it, as opposed to only 9.9% of the general population.

The same holds true for dental care. One-third of the parents of children, five-years old and less, report having no regular source of dental care, as opposed to 24.7% of the general population. One municipal water supply in the county (City of San Luis Obispo) currently fluoridates its drinking water.

Access is even more restricted for poor families. There are few Medi-Cal providers in the Coastal and North County regions of SLO County. There are no Medi-Cal dental providers at all in those two regions. Only 1,309 families eligible for the Healthy Families Program had signed up for the low-income health insurance for children as of June, 1999, less than 10% of those who are eligible in the County.

Mothers initiate breastfeeding exclusively 82% of the time in SLO County as opposed to 43% of the time in the state. Thus, the county rates high in the state's 58 counties.

While 39% of the children in the county are eligible for Child Health and Disability Prevention health screenings, less than half (46%) of those receive the assessment. Most of those who do (71%) are five years or younger. Three and one-half percent of the county's young children are referred for treatment for developmental delays.

The county fares better with immunizations as only 8% of Kindergartners are not up to date at the time of their admission to school, compared with 10% for the state as a whole. The difference widens, and rates rise at 24 months after admission, when 18% are not up to date in SLO County, versus 28% for California as a whole.

One in ten children (10%) in SLO County are exposed to environmental tobacco smoke in their homes or while riding in cars. This is about the same (9.1%) as the state mean. There are fewer homes in SLO County (17%) with no restrictions on smoking in the home than in California as a whole (21%). About 15% of the parents in SLO County report smoking cigarettes.

2. Prioritized Needs

The prioritized needs in this Focus Area are:

Allocation of Funds through the Commission

1) **Fluoridation of drinking water**: A one-time expenditure could provide the county water suppliers with the capability to fluoridate the county's

public drinking water. This would significantly reduce dental problems in young children.

2) **In-home visitation and support:** Such a program could meet a myriad of needs including parent skills education, referrals for well-baby exams, immunization monitoring, screening and referrals for mental health services, tobacco cessation support, screening for developmental progress, and injury prevention.

3) **Tobacco cessation for pregnant mothers and parents of young children**: Second-hand smoke is a significant cause of asthma and other childhood illnesses. Prevention education and cessation services would greatly improve the health and wellbeing of many children. Advocacy for public policies regarding exposure of children to second-hand smoke may also be appropriate.

4) **Dental preventive and restorative care**: There are very few dental care choices for low-income families in SLO County. Services to meet this need would include education and prevention for baby-bottle mouth, augmenting existing programs that provide health education, application of dental sealants and treatment of caries, and provision of dental treatment to young children who have no dental coverage.

5) **Screening for developmental problems and sensory deficits**: Services to meet this need would include increased screening opportunities, referrals to treatment, and education and support for parents.

6) **Postpartum depression**: Services to meet this need would include increased evaluation, education, prevention, and treatment.

7) **Perinatal and young family alcohol and other drug abuse**: Services to meet this need would include increased evaluation, education, prevention, and treatment.

8) **Comprehensive health care for young children**: Services to meet this need would augment the provision of a “medical home” for young children and their families.

9) **Enrollment in existing health care programs**: Healthy Families, Medi-Cal, and WIC are underutilized in San Luis Obispo County. Full enrollment would greatly improve the health and wellbeing of young children and their families. Services to meet this need would include education, social marketing, and advocacy.

VIII. GOALS AND OBJECTIVES

The potential possibilities of any child
are the most intriguing and stimulating in all creation.
Ray L. Wilbur

The Children and Families Commission of San Luis Obispo County has developed goals and objectives for each of the prioritized needs under the first Phase of Action (Allocation of Funds through the Commission). These are listed herein under the three Focus Areas. Indicators and outcomes which could be used to track the effectiveness of efforts toward reaching the objectives (depending upon the specific strategies and activities implemented) are also included for each goal as examples for prospective providers.

The Commission realizes that current funding through the Children and Families First Act is insufficient to work toward all of these goals and objectives at the same time. The reality is that services will be implemented to reach some of the goals and objectives, while others will have to wait, or be pursued through the other two Phases of Action. The Commission views these goals and objectives as an ambitious road map for the collaborative comprehensive county-wide development of an adequate and appropriate level of support for young children and their families.

A. PARENT EDUCATION AND SUPPORT SERVICES

Goals and Objectives

1) Prenatal and post-delivery education

Goal: To prepare parents of newborns for the demands of parenting in order to promote healthy pregnancies and newborns, to increase the ability of parents to provide safe and nurturing homes, and to provide early identification and referrals to services for families in need.

Objectives: To provide visitation and initial screening for 75% of pregnant women prior to hospitalization and for 95% of newborns and their families prior to hospital discharge (within two years of implementation of strategies and activities).

To complete a standardized family wellbeing assessment of 50% of the families by the third visit (within two years of implementation).

To provide extended visitation for up to six months to 95% of the assessed families that are determined to be in need of such support (within two years of implementation of strategies and activities).

1) Prenatal and post-delivery education (continued)

Indicators:
- Increased number of expecting parents who receive parenting information prior to birth.
- Increased number of parents of newborns who receive parenting information while in the hospital.
- Increased rate of participation in WIC, Medi-Cal, and Healthy Families.
- Increased rate of participation in parent education programs.

Outcomes:
- Decreased rate of late or no prenatal care.
- Increased rate of prenatal care begun in the first trimester.
- Decreased rate of home injuries to young children.
- Decreased rate of child abuse and neglect.
- Increased rate of use of existing services and programs.

2) Parenting skills training

Goal: To improve the ability of parents to recognize and respond in an appropriate, positive, and nurturing manner to the needs of their young children.

Objectives: To have at least 75% of the parents involved in parenting education courses complete the training (within two years of implementation of strategies and activities).

To increase the knowledge of participating parents regarding child development and parenting skills by at least 60% (within two years of implementation of strategies and activities).

To augment education and counseling concerning child abuse.

Indicators:
- Increased number of high quality parenting classes in all regions of the county.
- Increased number of parents attending high quality parenting skills training classes.

Outcomes:
- Increased rate of family self-sufficiency.
- Decreased rate of reported child abuse and neglect.
- Decreased rate of domestic violence.

3) Public awareness and social change

Goal: To change community norms to increase the appreciation for the importance of young childhood to human and social development.

3) Public awareness and social change (continued)

Objective: To increase by at least 10% the awareness of the community regarding the targeted care and health-related issues (within two years).

Indicators:
- Increased media coverage of child-related issues.
- Increased media activity promoting positive child development, health, and wellbeing.

Outcomes:
- Increased awareness of the importance of reading readiness.
- Decreased rate of home injuries to young children.
- Decreased rate of reports of child abuse and neglect.
- Increased rate of use of existing services and programs.

4) Literacy materials

Goal: To increase readiness of young children to learn to read.

Objective: To increase by at least 500 the number of books available in each region of the county to parents and literacy programs (within one year of implementation of strategies and activities).

Indicators:
- Increased number of reading programs.
- Increased number of children's books loaned to parents by libraries and literacy programs.

Outcomes:
- Increased number of parents reading to their children.
- Increased number of children entering Kindergarten who are reading ready.
- Increased reading scores on SAT-9 tests in elementary school grades.

B. CHILD CARE AND EARLY EDUCATION

Goals and Objectives

1) Stable and well-trained child care workforce

Goal: To increase salaries, support, and educational opportunities for child care providers.

Objectives: To have at least 50% of local child care providers join the state-wide (child development permit) matrix (within two years of implementation).

To increase the average pay of child care workers.

1) Stable and well-trained child care workforce (continued)

Objectives:(continued)

To have all Master Teacher-level providers receive at least the local self-sufficiency wages and benefits.

To have at least 15% of young children in licensed child care to be cared for in accredited programs (within two years of implementation).

Indicators:

- Increased number and quality of mentoring and networking opportunities for providers.
- Establishment of an incentive/compensation program linked to levels of training and professional experience.
- Increased amount of accessible information on accreditation.
- Increased incentives linked to accreditation in both family and center-based providers.
- Increased number of licensed programs.
- Increased skills in both licensed and licensed-exempt providers.
- Increased English proficiency in child care providers.

Outcomes:

- Increased number of licensed child care slots for young children.
- Decreased turnover rate in child care staff.
- Increased stability in children's caretakers.

2) Expanded child care services

Goal: To develop a wide range of child care services for young children that are available 24-hours per day, seven days per week.

Objectives: To establish licensed child care programs for young children during nontraditional hours (i.e., other than 7 AM to 6 PM and on weekends) in each of the four regions of the county (within two years of implementation of strategies and activities).

To increase the number of licensed child care programs that are trained to provide care for children with special needs, including those at risk for child abuse and neglect, by at least 10% (within two years of implementation of strategies and activities).

Indicators:

- Increased number of licensed child care slots during nontraditional hours.
- Increased number of licensed child care slots for children with special needs, including those at risk of child abuse.

2) Expanded child care services (continued)

Outcomes:
- Increased employment of single parents, and low-income mothers in two-parent households.
- Decreased percentage of parents of young children on public assistance.
- Increased academic performance in elementary school grades.
- Increased placement of special needs children in mainstream school environments.

3) Universal preschool for children, ages three to five, pilot project

Goal: To develop and implement a pilot project to demonstrate the effectiveness of preschool programs for children ages 3 to 5 years.

Objective: To establish at least one full-day, full-year preschool demonstration project (e.g., Head Start, State Preschool, Montessori, church-based, or any other appropriate program).

Indicators:
- Increased number of eligible children participating in programs.
- Increased number of children in licensed preschool programs.
- Increased parental involvement in preschool programs.

Outcomes:
- Increased rate of school readiness and school attendance.
- Increased academic performance in elementary school.
- Increased social ability and tolerance for diversity.
- Decreased behavior problems in preschool programs.

C. HEALTH AND WELLBEING OF CHILDREN

Goals and Objectives

1) Fluoridation of drinking water

Goal: To prevent tooth decay and other dental health problems in young children through the fluoridation of municipal and other public water supplies.

Objectives: To raise public awareness of the benefits of fluoridation and the lack of harmful effects.

To fluoridate at least seven public water supplies (within two years of implementation of strategies and activities).

1) Fluoridation of drinking water (continued)

Indicators:
- Policy statements by municipalities and water agencies of their intention to fluoridate drinking water supplies.
- Development of local partnerships to advocate for and contribute to the costs of fluoridation.
- Purchase and installation of fluoridation systems.

Outcomes:
- Reduced dental caries in young children.
- Reduced dental disease in young children.
- Increased nutritional health in young children.

2) In-home visitation and support

Goal: To improve child health through the establishment of an in-home visitation program for parents of newborns and infants.

Objective: To make in-home visits by qualified personnel to provide early identification of problems and developmental delays, monitor immunizations, promote smoke-free homes and tobacco cessation, teach and support parents in promoting health and wellbeing in their children, and make referrals to existing programs and services (within two years of implementation of strategies and activities).

Indicators:
- Increased number of participants in early programs for developmental disorders.
- Increased rate of complete immunizations.
- Increased knowledge of parents in subjects such as nutrition, illness prevention, and health promotion.
- Decreased level of second-hand smoke in homes.
- Increased rate of participation in health programs and services.

Outcomes:
- Decreased onset of serious developmental disorders.
- Decreased chronic and acute childhood illnesses.
- Increased indices of child health.
- Decreased rates of child asthma and other smoking-related illnesses.

3) Tobacco cessation for pregnant mothers and parents of young children

Goal: To reduce second-hand smoke in homes and cars with young children.

Objectives: To reduce smoking by pregnant women and parents of newborns by at least 50% (within two years of implementation of strategies and activities).

3) Tobacco cessation for pregnant mothers and parents of young children (continued)

Objectives: (continued)

To provide smoking cessation services to all pregnant women and parents of young children who request such services.

Indicators:
- Increased number of smoking cessation educational materials, classes, and counseling sessions.
- Increased number of parents involved in cessation activities.
- Increased number of parents committed to smoke-free homes and cars when children are present.

Outcomes:
- Decreased exposure of children to second-hand tobacco smoke.
- Decreased incidence of child asthma.
- Decreased incidence in children of other smoking-related disorders.

4) Dental preventive and restorative care

Goal: To improve dental health in young children through prevention and treatment.

Objectives: To provide dental health education to at least 50% of the parents of young children (within two years of implementation of strategies and activities).

To provide dental sealant treatments to at least 25% of young children from Medi-Cal-eligible families or families without health care coverage (within two years of implementation of strategies and activities).

To augment funding for dental health visits for children from Medi-Cal-eligible families or families without health care coverage.

Indicators:
- Increased number of parents receiving dental hygiene education.
- Increased number of children receiving dental sealant treatments.
- Increased number of children receiving dental care.

Outcomes:
- Decreased rate of caries in young children.
- Increased dental health in children.
- Increased nutritional level and general health in children.

5) Screening for developmental problems and sensory deficits

Goal: To increase early identification and treatment of young children with developmental disorders and sensory deficits.

Objectives: To increase by at least 35% the number of young children with developmental disorders who are identified and treated (within two years of implementation of strategies and activities).

To provide counseling and treatment for families with young children with developmental disorders.

Indicators:
- Decreased age of first entry into programs for children with special needs.
- Increased number of children in programs for children with special needs.
- Increased number and type of interventions available for children with developmental disorders and their families.

Outcomes:
- Increased academic performance in children with special needs.
- Increased number of children with special needs attending mainstream schools.
- Increased acceptance and understanding of children with developmental disorders.

6) Postpartum depression

Goal: To provide early identification and treatment for women who encounter depression after childbirth.

Objective: To provide screening of and referrals for mental health services to mothers who experience postpartum depression.

Indicators:
- Increased number of mothers screened for postpartum depression.
- Increased number of mothers receiving mental health services.
- Increased self-report of sense of closeness between mother and child.

Outcomes:
- Increased health and wellbeing of children whose mothers experience postpartum depression.
- Reduction in the rate of child abuse and neglect.

7) Perinatal and young family alcohol and other drug abuse

Goal: To prevent and treat alcohol and other drug abuse by pregnant women and parents of young children.

Objective: To provide alcohol and other drug prevention and treatment services to all parents who request them.

Indicators:
- Increased number of alcohol and drug prevention classes.
- Increased number of cessation and treatment groups.
- Increased number of parents involved in treatment groups.

Outcomes:
- Increased health and wellness of children in families with parents in prevention classes and treatment groups.
- Decreased incidence of child abuse and neglect.
- Decreased incidence of domestic violence.
- Increased rates of parental employment.
- Decreased incidence of crime.

8) Comprehensive health care for young children

Goal: To increase the number of families with young children who have a regular primary care provider, and increased access to comprehensive health care.

Objective: To expand the number of comprehensive pediatric sites that provide health care services, education, developmental assessment, social worker services, and nutritional education.

Indicators:
- Increased number of families making regular visits to a primary care provider.
- Increased number of services offered through comprehensive pediatric sites.
- Increased availability of psychological, nutritional, and screening services.
- Increased number of children receiving preventive care.

Outcomes:
- Increased child health.
- Reduction in the incidence of chronic and acute childhood illnesses and disorders.
- Reduction in the number of emergency room visits by families of young children.
- Decreased incidence of serious mental disorders among young children.

9) Enrollment in existing health care programs

Goal: To improve access to health care for those families of young children who are without coverage.

Objectives: To increase enrollment of eligible families in the Healthy Families Program to 75% (within two years of implementation of strategies and activities).

To increase enrollment of eligible children in Medi-Cal by at least 20% (within two years of implementation).

To increase enrollment of eligible children in WIC by at least 20% (within two years of implementation).

Indicators:

- Increased assistance to and activity by CBOs in outreach and enrollment.
- Increased number of employers who assist with HFP premiums for low-wage workers.
- Increased awareness of health care providers of programs.

Outcomes:

- Increased health in young children from low-income families.
- Decreased rates of chronic and acute illnesses in young children from low-income families.

IX. STRATEGIES AND ACTIVITIES

The soul is healed by being with children.
Fyodor Dostoyevski

During the planning process the Children and Families Commission of San Luis Obispo County identified strategies and activities for each of the prioritized needs under the first Phase of Action (Allocation of Funds through the Commission). These strategies and activities have been developed as examples which might be expected to lead to attainment of the goals and objectives. The strategies and activities are listed herein under the three Focus Areas.

The strategies and activities are presented as examples. The Commission is open to alternative strategies and activities as long as they are consistent with the Commission's vision, mission, and guiding principles, and meet the intent of the Strategic Plan and the general criteria that are listed in section *X. Resource Allocation* of this document. In fact, the Commission encourages creativity and innovation in the development of programs and services for young children and their families.

A. PARENT EDUCATION AND SUPPORT SERVICES

Strategies and Activities

1) Prenatal and post-delivery education

Strategies: Home and hospital visitation programs - visitation may be made by a public health nurse, parent mentor, social worker, or others. Home visits could be made to pregnant mothers, parents in the hospital at the time of birth, and/or to families in their homes after discharge. Both the Cal SAHF and Hawaii programs are considered appropriate models.

Activities:
- Educational material (e.g., *Welcome Baby Kits*).
- Information on existing programs and services.
- Education on health, parenting skills, nutrition, etc.
- Respite care.
- Parent mentoring.
- Support for ill children.
- Support for ill parents and/or emergencies.
- See also Need #2 under the Health and Wellbeing of Children Focus Area for additional activities.

2) Parenting skills training

Strategies: It is important that parent education enhance existing services, be supported by public policy, and coordinate with any home visitation and other services and programs aimed at parents of young children. PATHS and *Keys to CareGiving* are considered to be model programs.

Activities:
- Parent education classes.
- Individual parent education.
- Enhancement of skills in child communication, limit-setting, feeding and nutrition, child health, cooperation with spouse/partner, age and developmentally-appropriate behavior, etc.
- Enhance child abuse prevention and counseling programs.

3) Public awareness and social change

Strategies: Social marketing campaigns may utilize media (e.g., television, radio, print, billboards, etc.) to raise awareness and change social, institutional, and community norms.

Activities:
- Community education.
- Public relations (e.g., press releases, press conference, and solicitation of news and feature stories.)
- Advertising.
- Community organizing (e.g., public forums, community meetings, and door-to-door advocacy.)

4) Literacy materials

Strategies: Increase reading out loud to children by increasing the availability of books and other materials.

Activities:
- Purchasing books for libraries, child care facilities, preschools, parks, and other venues for families of young children.

B. CHILD CARE AND EARLY EDUCATION

Strategies and Activities

1) Stable and well-trained child care workforce

Strategies: Increasing the number of training opportunities including mentoring; educating, encouraging, and/or subsidizing child care providers to achieve accreditation; increasing the pay for child care workers; developing low-cost transportation for providers to get to training; and advocacy.

1) Stable and well-trained child care workforce (continued)

Activities:
- Regular training programs.
- Connection of pay increases with training.
- Subsidies for training.
- Classes and/or workshops on accreditation.
- Subsidies for accreditation.
- Provide awareness activities at employment sites.
- Identify license exempt providers through EOC and DSS CalWorks to provide training for these providers.

2) Expanded child care services

Strategies: Services could be expanded through funding, education, measurement of need and utilization of market forces, and advocacy.

Activities:
- Subsidies for providers to offer expanded hours.
- Market analysis to inform providers of the unmet needs.
- Training for providers in programming during nontraditional hours.
- Training for providers in services to infants and toddlers.
- Training for providers in services to children with special needs.

3) Universal preschool for children, ages three to five, pilot project

Strategies: Development of a pilot program for full-day, full-year preschool for children three to five years of age; and advocacy for expanded state funding.

Activities:
- Subsidies for development of a pilot program.
- Raise awareness in parents of the importance in developing cognitive skills in children.
- Development of transition program between preschool and Kindergarten.

C. HEALTH AND WELLBEING OF CHILDREN

Strategies and Activities

1) Fluoridation of drinking water

Strategies: Initial political and fiscal outlay to gain support of each public water source for fluoridation; gather funding, purchase and install equipment; and then small annual cost of fluoride and maintenance.

Activities:
- Raise public awareness.
- Decrease in public anxieties.
- Development of political support.

1) Fluoridation of drinking water (continued)

Activities:(continued)

- Development of economic support.
- Development of maintenance agreements.
- Installation of equipment.
- Ongoing procurement of chemicals and maintain equipment.

2) In-home visitation and support

Strategies: Home visitation program - visitation may be made by a public health nurse, parent mentor, social worker, or others. Home visits could be made to pregnant mothers, or to families in their homes after discharge. Both the Cal SAHF and Hawaii models are considered appropriate models.

Activities

- Educational material (e.g., *Welcome Baby Kits*).
- Information on existing programs and services.
- Education on health, parenting skills, nutrition, etc.
- Screening and referrals for developmental disorders.
- Screening and referrals for postpartum depression.
- Screening and advocacy for smoke-free homes and cars, and referrals to smoking cessation programs.
- See also Need #1 under the Parent Education and Support Focus Area for additional activities.

3) Tobacco cessation for pregnant mothers and parents of young children

Strategies: Education; social marketing; advocacy; and cessation services.

Activities:

- Raise parental awareness through education.
- Provision of cessation services.
- Individual counseling.
- Cessation classes.
- Smoke-free pledges.
- In-home advocacy for smoke-free homes and cars.

4) Dental preventive and restorative care

Strategies: Provision of services; education; prevention; and advocacy for public and provider policy change.

Activities:

- Subsidies for providers.
- Augment existing low/no-cost programs.

4) Dental preventive and restorative care (continued)

Activities: (continued)

- Advocacy for public funding (e.g., through Healthy Families Program, increased Medi-Cal reimbursement).
- Advocacy for reduced-fee/pro bono work by providers.

5) Screening for developmental problems and sensory deficits

Strategies: Education; training; screening and early identification; prevention; and treatment.

Activities:
- Education for parents regarding signs and symptoms.
- Training for providers to recognize signs and symptoms, including those disabilities which may be difficult to diagnose or which are less severe.
- Screening and referrals through home/hospital visitation program.
- Increase use of existing screening programs.

6) Postpartum depression

Strategies: Education; training; prevention; and treatment.

Activities:
- Education for parents regarding signs and symptoms.
- Training for providers to recognize signs and symptoms.
- Screening and referrals through home/hospital visitation program.
- Expansion of treatment options.
- Advocacy for expanded services.

7) Perinatal and young family alcohol and other drug abuse

Strategies: Education; training; prevention; and treatment.

Activities:
- Education for parents regarding signs and symptoms.
- Training for providers to recognize signs and symptoms.
- Screening and referrals through home/hospital visitation program.
- Expansion of treatment options.
- Advocacy for expanded services.

8) Comprehensive health care for young children

Strategies: Education; social marketing; increase use of existing programs; and advocacy for expanded services and programs.

Activities:
- Raise public awareness of needs and benefits.

8) Comprehensive health care for young children (continued)

Activities: (continued)

- Education of parents.
- Augmentation of existing services.
- Utilization of home/hospital visitation program.
- Training for other children's services providers regarding program availability and referrals.
- Advocacy for expanded public funding.

9) Enrollment in existing health care programs

Strategies: Education; social marketing; increase enrollment in existing programs; development of low-cost transportation for families to get to health care; and advocacy for expanded services and programs.

Activities:
- Raise public awareness of programs and benefits.
- Training for providers as to services, eligibility, and application.
- Education for parents.
- Provision of assistance in program identification and application.
- Advocacy for streamlined application procedures.
- Advocacy for expanded programs and services.

X. RESOURCE ALLOCATION

We do not inherit this land from our ancestors;
we borrow it from our children.
Haida proverb

A main priority of the Children and Families Commission of SLO County in its first two years is the development of the initial allocation process to enact the first of the three Phases of Action: Allocation of Funds through the Commission (Proposition 10 funding). The Commission has developed a timeline, budget, and allocation process for the first distribution of funding to support strategies and activities aimed at meeting the needs identified and prioritized during the strategic planning process.

A. TIMELINE AND BUDGET

The Commission plans to initiate two funding cycles within the next two years. The first cycle will begin in the summer of 2000, under which funding should be available for programs and services for 24 months beginning in January, 2001. The second cycle will begin in the winter of 2002, and funding is tentatively scheduled to be for a 24-month period beginning in July, 2002.

The Commission intends to use the following timeline in the distribution of funds to meet the needs of young children and their families in San Luis Obispo County.

Release of Requests for Proposals I	8/00
Deadline for Submission of Proposals I	10/00
Funding Awards I Announced	12/00
Services and Programs I Begin	1/01
Release of Requests for Proposals II	1/02
Deadline for Submission of Proposals II	3/02
Funding Awards II Announced	5/02
Services and Programs II Begin	7/02
Services and Programs I End	12/02

The Commission has developed an annual budget (which is displayed in a table on the next page) for the use of its funds from the tax on tobacco initiated under the Children and Families First Act. Approximately three-fourths (72%) of the funds are intended to be used in closing service gaps in order to meet the needs of young children and their families, with the remainder (38%) being used for other purposes.

The budget for direct services is intentionally undetailed. The Commission wishes to promote innovation and creativity in the development and implementation of strategies and activities to meet the prioritized needs contained in the Strategic Plan.

ANNUAL ALLOCATION BUDGET TABLE			
Expense Category			**Allocation Percentage (Amount)**
DIRECT SERVICES PROVISION **Parent Support/Education** • Prenatal and post-delivery education • Parenting skills training • Public awareness and social change • Literacy materials **Early Child Care and Education** • Stable well-trained child care workforce • Expanded child care services • Universal preschool for children, ages 3 to 5, pilot project **Health** • Fluoridation of drinking water • In-home visitation and support • Tobacco cessation and prevention • Dental preventive and restorative care • Screening for developmental problems & sensory deficits • Postpartum depression • Perinatal and young family alcohol and other drug abuse • Comprehensive health care for young children • Enrollment in existing health care programs			**72%** **($1,800,000)**
INVESTMENT RESERVE			**10%** **($250,000)**
OPERATING RESERVE			**5%** **($125,000)**
EVALUATION/DATA			**4%** **($100,000)**
INFRASTRUCTURE SUPPORT • Administration • Training - Agency • Media/Marketing	 7.9% 0.5% 0.6%	 ($197,500) ($ 12,500) ($ 15,000)	**9%** **($225,000)**
TOTAL			**100%** **($2,500,000)**

B. ALLOCATION PROCESS

The Commission intends to fund strategies and activities to meet the needs of young children and their families in San Luis Obispo County based on the priorities established in the Strategic Plan. Applicants are expected to adhere to the vision, mission, and guiding principles of the Commission, and are expected to develop strategies and activities which meet the following criteria:

1) **New (nonduplicative)** - the Commission is primarily interested in strategies and activities which are not presently being utilized in the county (or in a particular region), and is only secondarily interested in those which augment existing services;
2) **Preventive** - the Commission is interested in strategies and activities which are proactive in nature as opposed to those which are remedial;
3) **Research based** - the Commission is interested in strategies and activities which have been proven to be effective, or those which have some basis upon which to predict success;
4) **Innovative** - the Commission is interested in strategies and activities which are creative, and which offer fresh approaches to reaching the goals and objectives;
5) **Leveraged -** the Commission is interested in strategies and activities which will make use of existing streams of funding in addition to Prop 10 funding;
6) **Respectful** - the Commission will only consider strategies and activities which are appropriate to, and offer competence in diversity in culture, ethnicity, language, development, gender, and age;
7) **Outcome based -** the Commission is committed to a rigorous outcome evaluation which not only tracks the process of the activities, but that also provides demonstrated results in terms of changes in the behavior and health of young children and their families;
8) **Collaborative -** the Commission is interested in strategies and activities which are collaboratively planned and implemented; and
9) **Systems oriented -** the Commission is committed to working collaboratively with individuals and other service providers to develop a consumer-oriented comprehensive system of integrated services that are easily accessible to parents and young children.

All proposals submitted to the Commission must meet state requirements as presented in the Children and Families First Act as well as in the state implementing legislation and guidelines. Funding will only be allocated to fund new services. No funding will be provided for existing services currently funded through another source (i.e., no funding may be used to supplant local, state, or federal funds for any purpose).

The allocation process will proceed under a request for proposals format. A Request for Proposals will be released which details the expectations of the Commission, the guide-

lines and procedures for development of an application, and the expected evaluation process.

Three committees will be constituted in order to evaluate the proposals, one for each Focus Area in the plan. Each committee will consist of three Commissioners and an undetermined number of objective professional and community representatives. The committees will review and score the proposals according to a structured and objective rubric. The members of the Commission as a whole will make the final decisions regarding allocations based on the recommendations of these committees.

XI. EVALUATION

Grown-ups never understand anything for themselves, and it is tiresome for children to be always and forever explaining things to them.

Antoine de Saint-Exupery

A. STATEMENT OF COMMITMENT TO ONGOING EVALUATION

One of the mandates from the Children and Families First Act is to conduct outcome-based evaluation of all of the Commission's activities. A rigorous systematic evaluation component is essential to the implementation of the Strategic Plan.

The Children and Families Commission of San Luis Obispo County has been dedicated to structured and pervasive evaluation throughout its existence. An exhaustive needs assessment preceded strategic planning. Process evaluation has been performed through the planning process. And, evaluation will be a component of every future strategy and activity of the Commission and its funded partners.

Data which have been carefully identified and systematically collected provide information on program implementation and program impact. Evaluation data provide information concerning the processes by which strategies and activities are implemented. Data inform programs so that strategies and activities may be refined in order to increase their effectiveness. And data indicate whether or not strategies and activities are resulting in their intended outcomes.

The Commission is committed to program evaluation as an integral component of all of its strategies and activities. It is further committed to assisting and working collaboratively with service providers, professionals, and other planning bodies in coordinating and improving the county's capacity to gather, analyze, present, and utilize program evaluation data regarding young children and their families.

B. EVALUATION OF THE PLANNING PROCESS

The Commission has been evaluating its own strategic planning process. Community participants were asked to complete a brief survey of the Community Meetings and Focus Groups. The data from those surveys are presented in the *Community Meeting Evaluation Report,* which is appended to this document (see Appendix E).

The entire strategic planning process will be evaluated during the Summer of 2000. Interviews will be conducted with major participants in the process as well as with community representatives. The interviews will be used to assess the planning process so that future planning activities can be refined and improved based on experience.

Similar evaluation activities will be conducted periodically concerning strategies and activities employed by the Commission. For example, an evaluation of the allocation process will be conducted during and after its implementation.

C. EVALUATION OF COMMISSION ACTIVITIES

The Commission evaluation will measure program and service performance and results. The data collected and analyses performed will do three things:

1) Describe the individuals and groups implementing the strategies and activities.

One of the critical criteria for effective programming is the ability to replicate effective strategies and activities. In order to do so, it is necessary to have as much information as possible concerning the individuals and groups who are implementing the programs. Demographic data and documentation regarding the program and the individuals involved in it are indispensible for evaluating the program's results, and for replicating the program in other areas.

2) Monitor and track the processes of implementing the strategies and activities.

Not only must an evaluation provide information about the individuals and organizations providing the services, but data must also be collected about the program itself. Data must be gathered regarding the specific strategies and activities, the frequency and dosage of services, the target population(s), the immediate outcomes, and provider and client responses to the services.

3) Indicate the outcomes of the strategies and activities.

It is no longer sufficient to simply perform activities because we believe they will be successful. It is necessary to demonstrate that strategies and activities are resulting in their intended outcomes.

To do this, archival data must be collected in a thorough and consistent manner. Rigorous and systematic use of appropriate instruments and scientific program evaluation research design can measure indicators and outcomes of program effectiveness.

Taken together, all of these types of data can be statistically analyzed. When presented correctly a picture of the specific results of a program can emerge.

The ultimate intent of program evaluation is not to withdraw funding from ineffective programs. The intention is to constantly improve strategies and activities such that they cause the changes they are designed to cause. When they do so, program evaluation will help to disseminate effective programs so that they may be replicated in other areas.

The evaluation component will be developed and designed upon the selection of an Independent Evaluation Consultant. The consultant will perform the following tasks:

- develop a detailed evaluation work plan and timeline;
- incorporate program evaluation into all Commission activities;
- coordinate all evaluation components;
- consult with funded partners to assist in the evaluation of their strategies and activities;
- train staff in data collection and evaluation methodology and procedures;
- establish regular reporting formats and scheduling;
- compose regular reports for staff, program and service providers, and the Commission; and
- work collaboratively with other agencies and service providers to develop a uniform and cooperative system of data collection, storage, and analysis.